who underwent laparoscopy in 2012 were identified retrospectively from a trauma database. Patient injuries, imaging, operative findings, complications and length of stay were recorded.
Results: 22 patients underwent a laparoscopy for penetrating abdominal injuries (21 knife-stabbings, 1 gunshot injury). Abdominal FAST scan was positive in 10/22 cases, of which 3 proceeded directly to surgery. Of the remainder, CT suggested intra-abdominal injury in 10 cases. 13/22 patients underwent therapeutic laparoscopy [repair bowel injury (4), diaphragm repair (1), haemostasis of liver (3), haemostasis of abdominal wall (4), reduction of omental herniation (1)] with two conversions to laparotomy. Laparoscopy revealed additional injuries to CT in 13/19 patients, however in the 7 cases of a negative CT, laparoscopy did not reveal additional injuries. Median LOS 2.5 days (range 0-31). No patients had post-operative complications/occult injury.
Conclusion: Laparoscopic diagnosis and treatment for penetrating abdominal trauma appears to be safe in a specialised trauma unit and may reduce admission length.

1248: DOES A DEDICATED LAPAROSCOPIC EMERGENCY THEATRE HAVE AN EFFECT ON THE PROPORTION OF OPERATIONS PERFORMED LAPAROSCOPICALLY?

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Aim: To investigate the impact of a dedicated laparoscopic emergency theatre (LET) on the percentage of laparoscopic operations.
Methods: All the emergency procedures performed over a period of two years: one year before the installation of the LET (1 April 2008 to 31 March 2009) and one year after (1 April 2011 to 31 March 2012) were reviewed retrospectively. General surgical procedures were recorded and classified according to potential amenability to laparoscopy.
Results: The proportion of all general surgical operations that were potentially amenable to laparoscopic surgery fell from 735/1077 (68.2%) in 2008-09 to 831/1323 (62.8%) in 2011-12 ($p = 0.006$). Of those cases, 439/735 (59.7%) were performed laparoscopically in 2008-09 compared to 516/831 (62.1%) in 2011-12 ($p = 0.36$). Specifically, the proportion of appendicectomies completed laparoscopically increased from 236/271 (87.1%) in 2008-09 to 324/346 (93.6%) in 2011-12 ($p = 0.008$). Mean duration for laparoscopic cholecystectomy improved significantly from 165.3 minutes in 2008-09 to 136 minutes in 2011-12 ($p = 0.002$).
Conclusion: Although the data demonstrate a significant increase in the number of laparoscopic appendicectomies and diagnostic laparoscopies following the LET installation, there was no effect on the overall rate of laparoscopy. The surgeon's choice primarily determines the surgical approach.

1254: MANAGEMENT OF PELVIC FRACTURE IN MAJOR TRAUMA PATIENTS

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Aim: The audit was conducted to evaluate the initial management of major pelvic fractures after St Mary's Hospital was designated a Major Trauma Centre, and the management of pelvic fracture was moved there from Charing Cross Hospital.
Methods: Cases were identified from those discussed at the weekly trauma meetings, and a systematic search of the Emergency Department database. The case notes and radiology images/reports were then reviewed to collect relevant data. These were then compared to the standards set out by the British Orthopaedic Association Standards for Trauma.
Results: 73% of patients were immobilised with a pelvic binder either prior to or in the Emergency Department. 27% of unstable patients underwent embolisation, 53% went to theatre early. 92.9% received early CT (or immediately post Theatre if unstable). 31% had a cystogram. 40.4% of patients had their meatus inspected, 37.5% a PR, and 13.3% of women a PV exam.
Conclusions: This audit highlighted the importance of accurate and complete documentation – of both events and rationale. It also highlighted the need for complete assessment of the patients in the ED and raise awareness of the importance of perineal inspection in suspected pelvic injury.

1258: SURGEONS MAY NOT BE ABLE TO ACCURATELY ASSESS THE APPENDIX INTRA-OPERATIVELY

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Introduction: Laparoscopic appendicectomy has shorter length of stay (LOS) and return to activities. Most surgeons remove a macroscopically normal appendix during open surgery but debate exists regarding management at laparoscopy.
Methods: We prospectively collected data for laparoscopy and open procedures for right iliac fossa (RIF) pain over 8 months. Surgeons recorded seniority, macroscopic appearance of appendix, other pathology and procedure on a proforma. Formal histology was correlated with macroscopic findings and LOS calculated.
Results: 131/136 patients included. 1.15M: 1F with median age of 31 years (range 7-77). 119/131 had appendicectomy. Primary open surgery: 15/77 had macroscopically normal appendix and all underwent appendicectomy (100%). Laparoscopy: 14/46 had a macroscopically normal appendix and 3/14 (21%) had appendicectomy. 7/11 who did not undergo appendicectomy had other pathology at laparoscopy. 4/18 who had a macroscopically normal appendix removed had appendicitis on histopathology and other pathology in 7/18 (39% concordance). 14 patients with a macroscopically inflammed appendix had normal histopathology. Senior surgeon was consultant in 25% cases, registrar in 70% and core trainee in 5%. Median LOS was 2 days.
Conclusions: Surgeons may not accurately assess the appendix macroscopically. We advocate laparoscopic appendicectomy in cases of RIF pain where no other pathology is demonstrated.

1271: ARE WE ADHERING TO GUIDELINES COME RAIN OR SHINE?

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Aims: The Higher Risk General Surgical Patient document was issued by the Royal College of Surgeons of England in 2011. Our aim was to see if there was any seasonal variation in adherence to these guidelines.
Methods: This was a retrospective audit of patients undergoing emergency general surgical procedures (excluding urology, vascular and day-case procedures) over a 30 day period in the months of May and November 2012. Information including patient demographics, pathway they followed and outcomes were collected.
Results: A total of 108 patients were included in the study, 52 from May and 56 from November. Median ages were similar in the two groups. Time to review by the MRCS (registrar) was reduced in the winter month (5 vs 7 hrs). Despite increased demands on beds, the average time to theatre for the high risk patients was shorter in November compared to May (7.4 vs 25.7 hrs). Availability of level 2/3 care did not have an adverse effect on patient outcome. Appendectomies were carried out in a more timely fashion in November.
Conclusions: Results have confirmed that standards are being met in the 'busy periods', in fact they demonstrate improvement with reduced waiting times to review and speedier operations.

1322: ARE WE USING ABDOMINAL ULTRASOUND APPROPRIATELY TO ASSESS LOWER ABDOMINAL PAIN IN EMERGENCY GENERAL SURGICAL ADMISSIONS?

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Aims: Transabdominal ultrasound scanning is now readily available for emergency surgical patients in our trust. Our aim was to ensure that emergency ultrasound scans (USS) were being used appropriately.
Methods: All USS performed to investigate lower abdominal pain in adult emergency General Surgical admissions over a seven week period were recorded prospectively, collecting demographics, USS request details, USS results and patient outcomes.
Results: 497 emergency General Surgical patients were admitted during this period. 46(42 female) patients had USS for lower abdominal pain. 42 women (median age 25) had USS for lower abdominal pain. 38(90%) were of childbearing age(CBA) (16-49 years). 6(16%) of the USS performed in women of CBA revealed pathology of which 5/6 avoided surgery. In CBA with normal USS, 5 had laparoscopies and 1 had a CT. In women of non-